Women in Parliament: How does contraception affect participation?

An Honors Thesis (POLS 499)

by

Ariel Lee Skiba

Thesis Advisor
Dr. Misa Nishikawa

Ball State University
Muncie, Indiana

May, 2014

Expected Date of Graduation

May 3, 2014

Abstract

The importance of women in today's political sphere cannot be overstated. Women make up approximately 51% of any country's population but have yet to reach parity within a majority of the governments around the world. It is vital to study what influences the lack or presence of women within a governance system. This paper studies the influence of contraception on women's participation in parliament. In order to do this, a quantitative analysis was done by using a variety of data. The data was analyzed using regression analysis models and a scatterplot graph. Through the study of the tables produced by the regression analysis, it is clear that there exists a relationship between the prevalence of contraception and the presence of women in parliament.

Acknowledgements

I would like to thank Dr. Misa Nishikawa for her consistent and thorough advisement throughout the entirety of this project. Without her continued advice, suggestions, and support through the duration of the writing of this thesis, I surely would not have made it to the end.

I would also like to thank my mother and father for their support throughout my college career; without them, I would not have been able to pursue my passions through education and achieve the things I have here at Ball State.

Introduction:

The prevalence of women's rights in today's political discourse cannot be overstated. Women make up nearly 51% of the world's population but rarely reach parity within their governments. In fact, in only two countries of the world, Rwanda and Andorra, have women reached parity within the parliament[1]. In most countries, women are gravely underrepresented and, even in today's modern world, there are countless barriers which prevent women from full participation and equal representation in their governments. This paper seeks to examine factors which could possibly prohibit women from fully inhabiting their respective governments by focusing on women's health related issues.

The question this paper seeks to answer is thus: How does access to contraceptives impact the prevalence of women in their respective governments? If women make up 51% of the population and are equally able to vote for their representatives, why are there not more women in the government? Generally, this paper seeks to enter the dialogue on what conditions or factors can help explain the prevalence- or lack of, women in the government.

Feminist scholars have found that the presence of women in parliaments greatly increases the likelihood of gender sensitive issues gaining more legislative traction and floor time[2]. These scholars find that women are the most equipped to discuss and legislate on women's political

---

[1] Electoral quotas for women: An international overview. Commonwealth of Australia. Joy McCann. (Nov. 14, 2013). http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1314/ElectoralQuotas

[2]Women's Representation around the World: The Importance of Women's Participation in the Workforce. Daniel Stockemer, Maeve Byrne. (2012). http://pa.oxfordjournals.org/content/65/4/802.full#xref-fn-2-1

issues. Women are the ones closest to and most affected by their issues which include childcare, reproductive rights, and overall gender equality. Because of this, they are the most likely to have a complete understanding and effective dialogue concerning those issues.

Literature Review:

The majority of literature which focuses on the subject of contraception deals with the longterm biological repercussions of artificially controlling one's hormones (Assam, 1989; Prakash, 1986). In the political realm, women's participation in parliament is usually looked at from the vantage point of quotas (Kroot et. al., 2009; Zetterberg, 2009). Much of the research on quotas looks into how quotas affect the regional participation of women in their respective governments.

Much of the research into contraceptives ignores international political engagement implications and instead looks at domestic policies regarding emergency contraception and how it is presented in domestic political spheres.

None of this literature directly addresses the question that this paper seeks to answer regarding how the presence and abundance of contraception can affect a woman's ability to participate in her government. In so far as the research for this paper went, no literature on the direct correlation between contraception and parliamentary participation was found.

Theory:

Health care is considered by many countries to be such an inalienable right that it is provided for by the government through taxes. Reproductive care for both men and women is a very important part of comprehensive health care, and contraceptives should be considered a significant part of women's health care necessities. The proposition of this paper is that, through examination of the data, there will be a positive correlation between the variables concerning women's health care and the levels of their political engagement.

There are many barriers for many women which prevent them from serving significant roles within their government. Most of these barriers begin with inaccessibility of education or an inability to continue one's education. Many countries in Western and Sub-Saharan Africa and South Asia suffer from high rates of child marriage. Girls who are married young are less likely to continue their education and are 15 times more likely to die in childbirth[3] than their peers. These girls feed into a system of cyclical poverty and are unlikely to ever work a legislative role in their governments.

By allowing women the freedom to decide when to have children (a freedom which is typically taken away from child brides) and providing services where they can safely do so,

---

[3] International Center for Research on Women. (2010). http://www.icrw.org/child-marriage-facts-and-figures?gclid=CIKk9P7tib4CFcU-MgodbxEArQ

governments encourage not only economic growth[4], but also stimulate female participation in the government. This participation includes the attainment of seats of power within the government.

Women who are blocked from access to certain contraceptives are not only at a higher risk of pregnancy which can severely impair one's ability to continue education, but also of spreading and contracting infectious diseases such as HIV/AIDS.

Many women who are in need of family planning measures have already had children. These families are ones which desire to stem the growth of their family or prevent another pregnancy for a number of years. The usual reasons for a desire to wait or prevent another pregnancy are primarily economic. By inhibiting a family's access to birth control methods, cyclical poverty rates are increased. These women and their partners wish to use their resources to effectively take care of the family that they already have instead of stretching thin their financial wellness and encouraging the perpetuation of poverty.

By being allowed the opportunity to direct their lives and their reproductive choices, women gain confidence in themselves and in their ability to take an active part in their governments. This leads to a slowed population growth rate, more efficient allocation of economic resources, increased participation in the government by women, and more effective legislation on women's issues due to the increased participation.

Women who attain higher educations are more likely to be able to qualify to enter government fields as the electorate is more willing to vote for those candidates that they find adequately qualified.

---

[4] Studies by the OECD show that women are systematically the most untapped resource for economic growth around the world. When neglecting to allow or support women in the workforce, countries blacklist half of their potential labor force. This neglect can be seen where women are blatantly refused entry to the workforce, are not provided with sufficient childcare services or are expected to fulfill the role of stay at home mothers.

In order to help increase the number of women in the government, some countries, Like Rwanda, have instated quotas on their parliaments. Rwanda, whose ratio of women to men rose to 70% (7 women for 3 men) following the genocide[5], is now leading the world in female representation in the government with 56% of the country's parliamentary seats occupied by women in 2008 and an overwhelming 64% of women occupying the parliament in the 2013 elections[6]. This instance of female government participation combined with the dramatic changes that the genocide wrought has led to a significant change in the traditional gender roles for women of the country[7]. Women have now assumed leadership positions not only in their own homes, but in the country's governance system. The presence of a parity of women in the parliament has led to the creation of a gender sensitive constitution and the instigation of gender sensitive legislation.

Hypothesis:

The hypothesis that this paper wishes to examine is thus: Greater access to contraception increases women's participation in government, specifically in the lower house of parliament.

---

[5] World Savvy. http://worldsavvy.org/monitor/index.php?option=com_content&id=573&Itemid=1020

[6] Women win 64% of seats in parliamentary elections, maintaining number one spot worldwide. Kigali. (Sep. 23, 2013). http://www.gov.rw/Women-win-64-of-seats-in-parliamentary-elections-maintaining-number-one-spot-worldwide

[7] Rwanda: Women Hold Up Half the Parliament. Elizabeth Powley. http://www.idea.int/publications/wip2/upload/Rwanda.pdf

Data:

Each of the independent (x) variable analyzed will be health related. The dependent (y) variables will all be related to women's political engagement. The (x) variable that I will be addressing is contraceptive prevalence. The (x) variable is represented by the percentage of women, currently married or in union between the ages of 15-49 who are currently using or whose partner is using any method of birth control. These methods include both traditional barrier methods of birth control and more traditional methods of birth control including hormone pills.

The (y) variable I will be addressing is the percentage of women in the lower house of the parliament after each country's most recent election[8]. This variable is also represented as a percentage and helps eliminate the inconsistency which would be inherent to a variable which merely counts the number of women in the parliament. By looking at the percentage of women it is easier to get a more accurate read on women's representation in the parliament.

In order to test my hypotheses, I will be using datasets obtained from the World Health Organization, the World.sav dataset, United Nations Data, PewResearch, The World Bank, and the Inter-Parliamentary Union. All of the variables included in the World data sets were compiled and made available by Pippa Norris, John F. Kennedy School of Government, and Harvard University. The data attained from the W.H.O. is provided for public access by the Global Health Observatory. The dataset compiled for this paper includes 191 individual country cases.

---

[8] As of February of 2014.

After running a bivariate analysis on the two main variables, control variables were introduced. These variable include a control for democracy, economy, religion/culture, and education. These variables are represented by a Freedom House democracy ranking, GDP per capita, percentage of the population which is Muslim, and percentage of the population which is literate, respectively.

Methods:

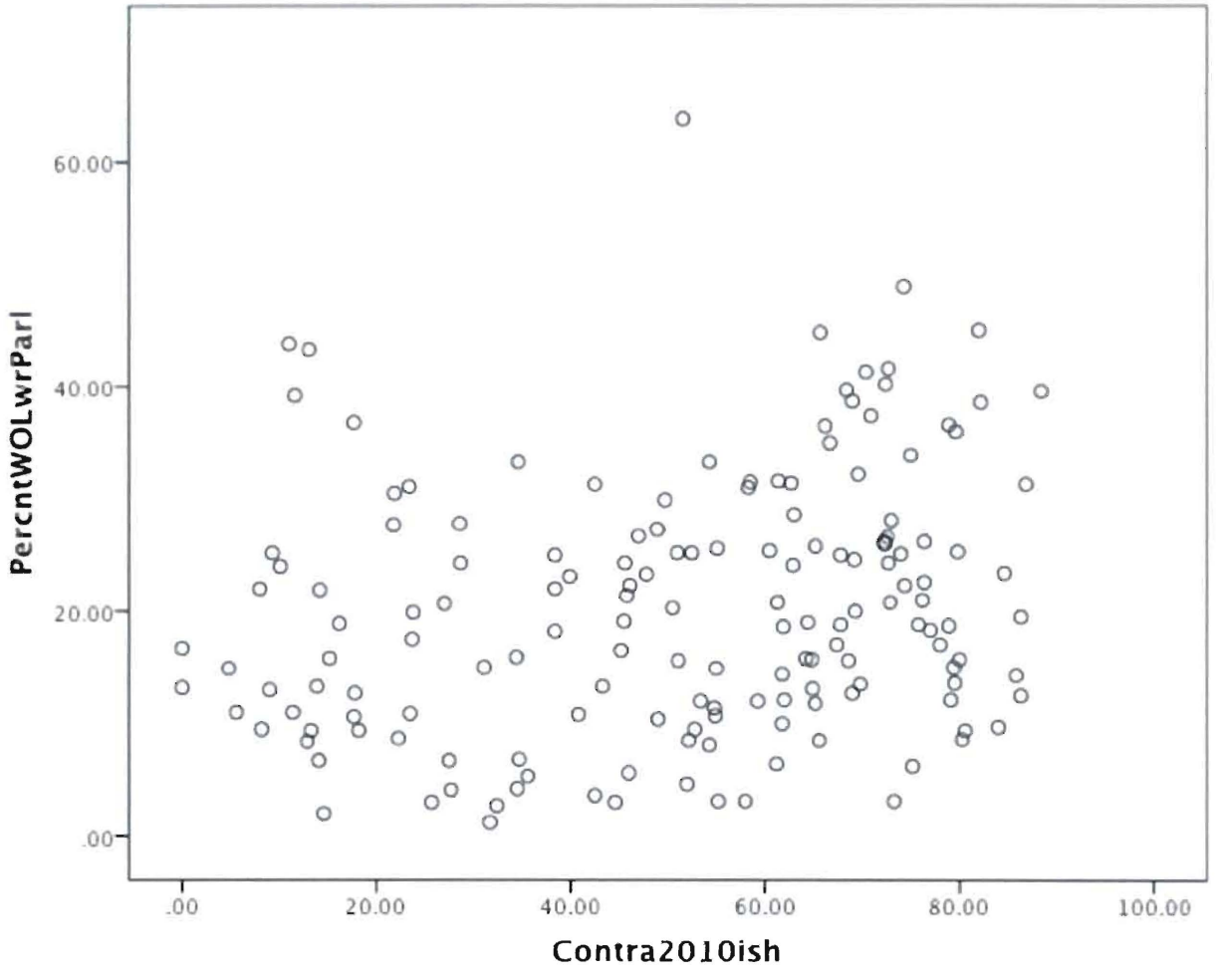
To analyze the data, a regression analysis is used. First, the two main variables are analyzed at the bivariate level to asses their relationship. Then the model is run with the introduction of a single control variable at a time. Finally, the full model is run with every control variable used in the regression analysis.

In addition to the regression analysis, a scatterplot graph is created using the main independent and dependent variable.

Tables:

Scatterplot:

Contraceptive prevalence in 2010[9] and percent of women in the lower house of parliament as of February 2014.



[9] For some cases, prevalence of contraception could not be found for the year 2010, and in these instances the closest year was chosen instead.

This data table is a visual representation of the relationship between contraceptive prevalence and women in parliament. A distinct trend is difficult to see, but a slight positive trend can be seen in the scatterplot between the two variables.

Regression Analysis:

Variable	*Bivariate*	*Dem.*	*Econ.*	*Culture*	*Edu.*	*Full Model*
Contraceptive Prevalence	.106*** (.037)	.095** (.040)	.054 (.040)	.060 (.044)	.154** (.076)	.106 (.080)
FH Dem. Rating		.353 (.483)				-.523 (.380)
GDP/Cap.			.000 (.000)			.000 (.000)
% Muslim				-.066** (.027)		-.80** (.037)
% Literate					-.1 (.103)	-.191* (.110)
Constant	14.8 (2.11)	13.802 (2.581)	16.413 (2.086)	19.82 (2.82)	20.56 (6.378)	34.196 (7.725)
Adj. R2	0.042	0.039	0.036	0.074	0.030	0.041
N	158	158	141	129	88	65

In the regression analysis, it is easier to see the relationship between the variables. Here, the coefficients are consistently positive and significance can be seen in some models across the whole chart. Significance at the bivariate level is very high and remains decently high for the controls of democracy, culture, and education. Even when the full model is run significance can still be seen.

Unfortunately, as more variables are added as controls, the number of cases drops drastically. With this lack of cases, it is possible that the full model's data is skewed in regards to significance.

Conclusion:

The regression analysis presented a clear connection between women in parliament and the prevalence of contraception within the country. The relationship between theses two variables can range to anything from social factors- higher social equality for the genders means higher percentage of contraception, to direct causation- the presence of contraception directly increases the number of women seen in parliament. However, it is impossible to make such judgements on causation without further intense study of the topic.

One way to further enhance this study and contribute more to the discussion regarding women in government would be to expand the number of cases available for study. This could be done by expanding the number of years analyzed and doing a time-series panel and looking at how the presence of contraception and prevalence of women changes from year to year.

Additional study is also needed to help further analyze the causal direction of the data. Ultimately, however, the study of this relationship is relevant and deserves more attention.

Works Cited:

Contraception Research. Assam. Economic and Political Weekly, Vol. 24, No. 24 (Jun. 17, 1989), pp. 1308-1309

Do Gender Quotas Foster Women's Political Engagement? Lessons from Latin America. Pär Zetterberg. Political Research Quarterly, Vol. 62, No. 4 (Dec., 2009), pp. 715-730

Gender Quotas and Models of Political Citizenship. Mona Lena Krook, Joni Lovenduski and Judith Squires. British Journal of Political Science, Vol. 39, No. 4 (Oct., 2009), pp. 781-803

Hormonal Methods of Contraception: Government Indifferent to Dangers. Padma Prakash. Economic and Political Weekly, Vol. 21, No. 17 (Apr. 26, 1986), pp. 733-734

Muslim Population by Country. PewResearch Religion and Public Life Project. (Jan. 2011)

The World Bank Group. (2014)

United Nations, Department of Economic and Social Affairs, Population Division (2013). *2013 Update for the MDG Database:* Contraceptive Prevalence (POP/DB/CP/A/MDG2013).

Women in National Parliaments. Inter-Parliamentary Union. (Feb. 1, 2014)

World Data Set. Pippa Norris, John F. Kennedy School of Government, and Harvard University.

World Health Organization. (2014)

Supplements:

In addition to writing the thesis, I also had to create a presentation and present it before a panel of Political Science professors. The presentation was to be 15 minutes long and be a summation of my thesis research. In conjunction with my presentation, I also needed to be able to answer follow-up questions from the professors. I presented on April 25, 2014. Enclosed are the slides from my presentation.

Women's Reproductive Healthcare and Political Participation

Ariel Lee Skiba

Question

- *How does the prevalence of contraceptives impact the presence of women in the legislatures of their governments?*
- *What can explain the prevalence, or lack there of, women in the government?*

Background

- *Majority of research on contraception is regional or focuses on fertility (Jeffery & Jeffery, 2000; Assam, 1989)*
- *Political participation of women analyzed via quotas (Panday, 2008; Jones, 2004; Baldez, 2004)*
- *Lack of research into direct political ramifications of contraception*

Theory

- *Barriers to education:*
  - *Marriage*
  - *Child rearing*
  - *Lack of support from government*
- *Freedom of choice allows for focus on education and economics.*
- *Higher education opens paths for governmental job attainment.*
- *Contraceptives allow for women to direct their lives.*

Hypothesis

- *Greater access to contraception increases women's participation in government.*

Data

- *Datasets obtained by the World Bank, Inter-Parliamentary Union, United Nations, PewResearch, and the World Health Organization.*
- *191 Countries*

Variables/ Models

Main Dependent:

- *% Women in Parliament (IPU)*

Main Independent:

- *Contraceptive Prevalence (United Nations)*

Models:

- *Regression analysis*
- *Scatterplot*

Control Variables:

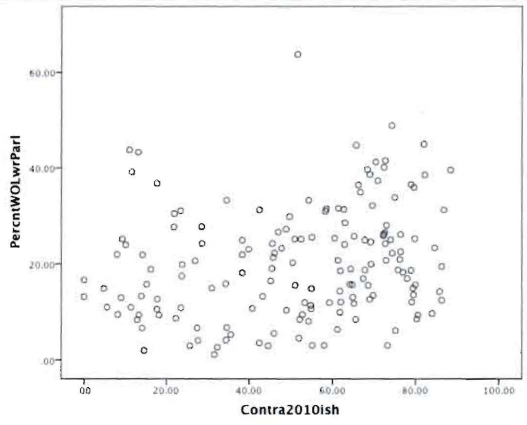
- *Democracy (World Dataset)*
- *GDP/Capita (World Bank)*
- *% Muslim (PEWResearch)*
- *% Literate (World Bank)*

Variables

- *Contraceptives:*
  - *Any method (modern, barrier, etc.)*
  - *% Women aged 15-49 in union*
- *% Women in Parliament*
  - *as of Feb. 2014*

Scatterplot

Contraceptives & Women in Parliament



Regression Analysis

Variable	Bivariate	Dem.	Econ.	Culture	Edu.	Full Model
Contraceptive Prevalence	.106*** (.037)	.095** (.040)	.054 (.040)	.060 (.044)	.154** (.076)	.106 (.080)
FH Dem. Rating		.353 (.483)				-.523 (.380)
GDP/Cap.			.000 (.000)			.000 (.000)
% Muslim				-.066** (.027)		-.80** (.037)
% Literate					-.1 (.103)	-.191* (.110)
Constant	14.8 (2.11)	13.802 (2.581)	16.413 (2.086)	19.82 (2.82)	20.56 (6.378)	34.196 (7.725)
Adj. R2	0.042	0.039	0.036	0.074	0.030	0.041
N	158	158	141	129	88	65

Interpretation

- *The coefficients are consistently positive.*
- *Significant in some models*

Conclusion

- *Find way to expand case numbers*
- *Causal direction needs to be studied more*

Sources

- *World Health Organization (WHO), 2014.*
- *World Data Set*
- *Inter-Parliamentary Union, 2014.*
- *The World Bank Group, 2014.*
- *United Nations Data, 2014.*